WISCONSIN LEGISLATURE

P. O. Box 7882 Madison, WI 53707-7882

Testimony of Senator Jim Sullivan and Representative Christine Sinicki
Regarding Senate Bill 429/Assembly Bill 644
Help Firefighters and Officers Exposed to Infectious Diseases
Senate Committee on Labor
March 10, 2010

Good morning, I am Senator Jim Sullivan. My co-author, Representative Christine Sinicki, could not make it as she is chairing another committee.

Representative Sinicki and I both represent districts in the Milwaukee area, and we, along with most of our neighbors, remember quite vividly the Patrick Cudahy Plant fire last Independence Day weekend. As citizens rushed out, first responders rushed in. It was a massive disaster relief effort, with 27 fire departments, 75 police officers and sheriff's deputies and about 8.5 million gallons of water required to fight the blaze. The valiant efforts of the first responders prevented any loss of life and strictly limited the impact of the blaze on the plant and the surrounding community. To our brave first responders, it was just another tough day on the job.

Firefighters, police, emergency medical personnel and correctional officers put their lives on the line to keep us safe every day. Now, it is our turn to protect them by making sure they get the benefits they deserve if they are disabled due to a disease they contracted on the job.

Under current law there exists a ***presumption***: if a firefighter develops heart disease or certain types of cancer, it is ***presumed*** that the disease was caused by exposure to materials they contacted in the process of fighting fires. This presumption entitles the firefighter to disability benefits if he or she is no longer able to work or the family a death benefit if death should occur. The presumption was established in law as a result of public understanding of the causal link between heart and lung disease and certain types of cancer and the carcinogens present in smoke.

There is currently no "presumption" if a firefighter, EMT, law enforcement officer, or correctional officer is exposed to infectious diseases like hepatitis, meningitis, or HIV while on the job and is permanently disabled as a result. The bill before us today specifies that protective occupation participants (police, fire, EMS, correctional officer) be extended the 'presumption' for the diseases specified in the bill.

Wisconsin has long recognized that our firefighters, law enforcement officers and correctional officers have dangerous professions. Our society recognizes the critical nature of what they do. In exchange, we make sure they have proper training and the best equipment available.

It is not possible to protect these brave men and women from all the dangers they face. That is simply the nature of their profession. For those who end up sacrificing their lives, we provide their families with a special death benefit. Fortunately, not all injuries result in death. Unfortunately, some of those injured in the line of duty become permanently disabled. For those

who are not able to work again at their old jobs, the state (through their employer) provides them with duty disability benefits.

To receive the duty disability benefits a firefighter, law enforcement officer or correctional officer needs to prove that the injury occurred on the job. That is not difficult when the injury is caused by a gunshot wound or a fall from a collapsing building, but not all injuries or disabilities are that easy to prove. Cancer might be caused by exposure to certain carcinogens contacted at a chemical fire. Heart and lung ailments may develop over time.

Passage of this bill will not guarantee any employee access to unemployment insurance; rather, it will require the employer to rebut the employee's assertion of the presumption should the employer move to deny payment of the benefit.

Fortunately, exposure to such infectious diseases is extremely rare and we would hope that would continue to be the case. However, if an infection does occur, we believe the use of the same presumption that is now available to firefighters for cancer or heart disease should also apply to protective occupation participants, who are exposed to infectious diseases in the line of duty.

Thank you.

INFECTIOUS DISEASE TESTIMONY
SB-429
Senate Committee on Labor, Elections and Urban Affairs
March 10, 2010

Good morning, Chairman Coggs and Committee members. My name is Mike Woodzicka. I am State President of the Professional Fire Fighters of Wisconsin. The PFFW represents over 2800 fire fighters from over 60 communities in Wisconsin. In addition to being fire fighters all our members are licensed or certified to be medical first responders, EMT's or paramedics

With me today is Fond du Lac fire fighter/paramedic Scott Kettlehut. Following my testimony, Scott will tell you of his experiences with tuberculosis.

I am here testifying in support of SB-429. Before I start, I want to thank the authors of the bill: Senator Sullivan and Representative Sinicki for their introduction of this important legislation. I also want to thank all of the other sponsors of this bill.

When fire fighters, public EMS personnel, law enforcement officers, or correctional officers are permanently disabled because of an injury on the job, they are eligible for disability payments called *Duty Disability.*

These Duty Disability benefits do not occur automatically. Two conditions must first be met:

1. The disability must be permanent; in that the person is not able to perform their normal functions.
2. The employee must prove that the disability was caused by the job.

Fire fighters and EMS personnel currently have a presumption that a disability is job related if they become disabled due to heart or lung disease or develop certain types of cancers. In these cases, the disability is "presumed" to have been caused by the job, and thus if permanently disabled, are eligible for Duty Disability benefits.

The "presumption" is rebuttable, meaning the employer could challenge the source of the disability being job-related. This puts the burden of proof on the employer, rather than on the employee. The Department of Employee Trust Funds and its Board would ultimately make that final determination.

The Heart and Lung Presumption has been law since 1961 and the Cancer Presumption has been in effect since 1997. Looking at the trends, there has been an average of one fire fighter developing cancer each year since the passage of the bill.

A growing concern among fire fighters and law enforcement personnel is the increasing likelihood of contact with an infectious disease. We all know we live in a hostile world. Our chances of being exposed to infectious diseases increases as diseases spread around the world. The danger of being exposed from both intentional and accidental sources seems to escalate daily.

Infectious diseases have become a hazard to fire fighters too big to ignore. Progressive steps towards protecting fire fighters from the risks of these hazards need to be taken. Fire fighters and emergency medical responders can be exposed to both bloodborne pathogens and airborne infectious agents on a regular basis as a result of their daily duties. The infectious disease status of the victim is almost never known to the fire fighter while he or she is rendering emergency services. All of these factors support the need for presumptive legislation as it relates to infectious disease.

To date, we are aware of only one case in Wisconsin where a fire fighter or law enforcement personnel became permanently disabled from an infectious disease. Despite that fact, there have been other cases of exposure. Fortunately none of these cases have yet resulted in any permanent disabilities.

This legislation, when passed, will make it a little easier each day for our families as we leave home to face unknown dangers. We do our job regardless of the consequence to us; that is just our nature. However, it is our families who worry as we walk out the door heading for our fire stations.

With the threat of both international and domestic terrorism always facing us, as well as new strains of viruses, this legislation is designed for the day that we all hope never arrives.

SB-429 identifies 11 different types of infectious diseases with whom fire fighters, EMS, and law enforcement are likely to come in contact with. At least 22 other states already have Infectious Disease Presumption laws similar to what is being proposed here.

I hope that you will give us the same protection that is enjoyed by our brothers and sisters in these other states. Your support for SB-429 will be greatly appreciated.

I am glad to answer any questions that you might have or if you want to wait until after Scott testifies that would be fine with me.

INFECTIOUS DISEASE TETIMONY
AB-644
Assembly Committee
January 13, 2010

My name is Scott Ketelhut. I've been a professional fire fighter/paramedic in Fond du Lac for over 24 years.

Fond du Lac has an annual test for Tuberculosis. It was in February 1997 that I had a positive reaction to my annual TB test. My test in 1996 was negative, therefore sometime between the test of 1996 and 1997; I came in contact with a person who infected me with TB. During that 12-month period, I estimate I responded to over 450 paramedic calls and 200 fire calls.

Treatment for the infection included taking a daily oral medication for a full year. Luckily, the medication stopped the TB infection from progressing to the TB disease.

I wasn't able to pinpoint a specific person who infected me so initially the city denied paying any bills that accumulated, such as specimen samples, blood work, x-rays, or doctor visits. I was going to appeal the city's denial but when the fire chief said he would be sitting on my side of the table during any public hearings, the city agreed to pay the outstanding bills that my health insurance did not cover.

It is necessary for me to continue to monitor my situation. Future treatments include annual x-rays for 10 years to look for presence of the disease.

I am very fortunate for the annual testing that caught the TB infection before it became the actual TB disease. I am also thankful that Fond du Lac eventually agreed to cover expenses this caused me.

However, this does help to illustrate the need for AB-644. With my responding to over 650 calls in the 12 month period I think it was safe to assume I was exposed to someone that had tuberculosis but they might not even have know it. Without the presumption legislation, I would have had to prove where I got it and in this case, that would have been impossible. I thus would not have been able to collect disability benefits if my exposure had resulted in an actual disability.

It is unsafe not having a presumption law for the firefighters, paramedics and EMS's when we deal everyday with patients who may infect us.

In closing, I would like to say we, the fire fighters, should have a law to protect "rescuers" from disease such as TB and other infectious diseases. Thank you for your time on this very important matter.

WI Fire & EMS Legislative Leadership Coalition

Dear State Legislator:

We are writing to register our support for AB-644 the Infectious Disease Presumption legislation.

The Fire and EMS Coalition is made up of the Wisconsin State Fire Chiefs Association, Wisconsin Fire Chiefs Education Association, Wisconsin State Fire Fighters Association, Wisconsin Fire Inspectors Association, Wisconsin Society of Fire Service Instructors, Wisconsin EMS Association, Professional Fire Fighters of Wisconsin, and WI. Chapter 25 International Association of Arson Investigators.

Members of our organizations are almost in daily contact with members of the public that are in need of medical attention. When we arrive on the scene we often do not know anything about the patients we have been called on to provide emergency care for. We do it regardless of the consequence that is simply what we have been trained to do and are expected by the public to do.

As a result it does happen that we are exposed to certain infectious diseases but are not aware of it at the time. The period of incubation may be days, weeks or even months. Thus once we realize we have a medical problem it can be long after the exposure. We might have been on dozens or even hundreds of other EMS calls since the exposure.

As much progress as medical technology has made in recent years it is still not possible to prove where every exposure may have occurred. Thus under the current system it is very possible that fire fighters or EMS personnel has become disabled due to an infectious disease that he or she contacted on the job but can never prove exactly when and where the exposure occurred. Without the proof, disability benefits are denied and we think that is unfair.

Therefore we urge you to support AB-644.

Respectfully,

John C. Gee,
Secretary, Wisconsin Fire & EMS Legislative Leadership Coalition

PROFESSIONAL FIRE FIGHTERS OF WI, INC.

WI CHAPTER INTERNATIONAL ARSON INVESTIGATORS ASSOCIATION

WI FIRE CHIEFS EDUCATION ASSOCIATION

WI FIRE INSPECTORS ASSOCIATION

WI SOCIETY OF FIRE SERVICE INSTRUCTORS

WI STATE FIRE CHIEFS ASSOCIATION

WI STATE FIRE FIGHTERS ASSOCIATION

WI. EMS Association

Testimony of Richard M. Duffy
On behalf of
The Professional Fire Fighters of Wisconsin
March 10, 2010

Good morning, I am Richard M. Duffy, Assistant to the General President for Occupational Health, Safety and Medicine at the International Association of Fire Fighters. This morning I will discuss the important topic of chemical-induced cancers that our Public Safety and Emergency Response personnel, fire fighters in particular, may be subjected to while performing their duties. On behalf of fire fighters throughout the State of Wisconsin, we are here today to discuss evidence that links higher rates of certain infectious diseases with tasks that involve fire fighting emergency response activities, particularly when that response occurs in a dangerous environment containing unknown hazards. The known and potential risks to which these individuals are exposed, on our collective behalf, certainly warrants the passage of legislation that addresses the job-related health consequences suffered by our emergency responders.

Before going ahead, I believe it is important for you to understand what our organization is and whom we represent at these hearings. The IAFF is an international union affiliated with the AFL-CIO and the Canadian Labour Congress. At the present time, we represent over 296,000 paid professional fire service employees in the United States and Canada. The membership of the IAFF is employed by various parties that include the federal government, states, counties, municipalities, fire districts, airports, industrial manufacturers, and so on.

The profession of fire fighting is and has always been a hazardous occupation. Every year the IAFF publishes an annual *Death and Injury Survey,* and each year the hazards of fire fighting continue to exist and display ever-varied forms. Fire fighter line-of-duty fatalities have ranked fire fighting among other publicized hazardous occupations in the private sector, such as mining and construction.

Infectious diseases have become a hazard to fire fighters too big to ignore. Fire fighters and city governments need to take progressive steps towards eliminating the risks of these hazards. Fire fighters and emergency medical responders can be exposed during motor vehicle accidents in which blood and sharp surfaces often are

present, by rescuing burn victims, and through the administration of emergency care. The victim may require extrication from a difficult to access accident scene, such as a motor vehicle accident or poorly accessible building. There may be broken glass or other sharp objects at the scene that are poorly visualized, and the lighting at the scene may be minimal. In addition, if the victim is "bleeding out" and needs to be extricated quickly to save his/her life, the emergency provider may act in haste, with disregard for his or her own safety. Fire fighters also may be involved in emergency medical treatment at the scene, including intravenous line insertion and blood drawing. The infectious disease status of the victim is almost never known to the fire fighter while he or she is rendering emergency services. All of these factors combine to place the fire fighter at increased risk of contracting a bloodborne contagious disease through a puncture wound, skin abrasion or laceration that becomes contaminated with infected blood from the victim.

Education and training are the most effective means available to limit the risk of contracting a bloodborne contagious disease in fire fighters. The risk of contracting an infectious disease, and methods used to avoid exposure, should be a part of every fire fighter's education. Universal precautions, such as the wearing of protective gloves, safety glasses, respirators, and gowns, must be provided and used whenever exposure to bodily fluids is possible. These precautions must be taken whether or not the infectious status of the patient is known. If these precautions should fail you need to have additional avenues of protection. Exposure notification laws can protect you after an unsuspected infection.

Fire fighters and emergency responders are exposed to infectious diseases quite frequently in their daily work activities. In a US Federal Government Study conducted during the development of the federal OSHA Bloodborne Pathogen Standard (29CFR1910.1030 OSHA Regulatory Impact and Flexibility Analysis) it was shown that 98 % of EMT's and 80% of fire fighters are exposed to bloodborne diseases on the job. Further, the National Fire Protection Association estimates in their latest *Report on U.S. Firefighter Injuries* that there were 10,380 exposures to infectious diseases (e.g., hepatitis, meningitis, HIV, others) among fire fighters in 2008.

Description of Diseases

The diseases which the US Centers for Disease Control and Prevention have classified as life threatening and notifiable[1] under the provisions of federal law are:

[1] Subtitle B of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 contains provisions for the notification of emergency response personnel exposed to infectious diseases while attending, treating, assisting, or transporting a victim. The notification provisions of this bill took effect on April 20, 1994. The law provides for emergency response employee notification following a documented exposure to blood or body fluids, verified by the receiving hospital. It also provides for automatic notification of the emergency response employee if the transported patient is found to have infectious tuberculosis. This notification by the medical facility must be made to the designated officer in writing as soon as possible, but within a period not exceeding 48 hours after the receipt of the request by the designated officer. The designated officer must then inform the employee or employees involved of the determination. The Ryan White HIV/AIDS Treatment and Extension Act of 2009 has now reestablished these provisions.

TB
HBV
HBC
HIV
Uncommon/Rare Diseases
- Diphtheria
- Hemorrhagic Fevers
- Meningococcal Disease
- Plague
- Rabies

This legislation has recently been reauthorized and thus it reestablishes the notification provisions that were in the original legislation. The IAFF is currently working with CDC and the National Institute for Occupational Safety and Health to update this list. It is important to note that the 'list' established under this legislation is very powerful – it essentially determines what infectious diseases should be considered 'potentially life-threatening' to emergency responders. The list is also used to determine whether or not emergency responders must be notified of an exposure.

We further wish to provide general information regarding some of these diseases and the relationship to fire fighters and emergency medical responders.

Tuberculosis

Tuberculosis is a disease caused by a family of organisms known as *Mycobacteria*. The disease commonly known as tuberculosis (TB) is caused by one species of *Mycobacteria,* called *Mycobacterium tuberculosis (M. tuberculosis)*. Other members of the *Mycobacterium* have been found to infect people with compromised immune systems such as AIDS or cancer patients on chemotherapy. These organisms (*Mycobacterium avium intracellulare, Mycobacterium kansasii*), ordinarily pose no risk to normal individuals.

TB is an ancient disease that used to be widely feared throughout the world, accounting for large numbers of deaths and chronically ill persons. In part, this is because TB thrives and spreads best in crowded conditions among people with weakened resistance, conditions often found among the poor.

After several decades of declining incidence, the number of new cases of tuberculosis is now on the rise, particularly in congested urban areas where there is also a rise in the crowded and poor social conditions that are prime ingredients for TB. In addition, in certain populations (prisoners, indigents, recent immigrants, institutionalized patients, and AIDS patients) the incidence and prevalence of TB is a major concern to public health officials. Fire fighters and EMS personnel are routinely exposed to all of these populations.

Tuberculosis is transmitted by individuals with active infection through airborne **respiratory droplets**, produced by coughing, sneezing, or even talking. These respiratory droplets can survive suspended in the air for several minutes, particularly if

there is poor air circulation, so that the person with TB does not even have to be in the room for the air to be infectious. However, in circulating air the number of infectious respiratory droplets quickly drops off. Sunlight and ultraviolet light also kill the TB germs.

In a normal person with a normal immune system, exposure to *M. tuberculosis* is followed by a strong immune response. The droplet with the organism is inhaled deep into the lungs, where the organism initially multiplies. A healthy immune system is able to contain the infection easily, but while the infection may be controlled by the immune system, the organism will remain dormant in the body, and can become active again, even may years later unless treated medically. That is the reason that TB testing, and a complete course of treatment, are necessary to protect against later illness.

OSHA and the Centers for Disease Control and Prevention (CDC) have recognized the increasing incidence of TB and multi-drug resistant TB cases in the American population and its impact on TB exposures in the U.S. occupational health care setting. This document is based upon the recommendations of the CDC in its October 1994 Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Facilities. The CDC guidelines recommend the control of TB be accomplished by early identification, isolation, and treatment of persons with TB, use of engineering and administrative procedures to reduce the risk of exposure, and through the use of respiratory protection.

OSHA will conduct inspections for occupational exposure to TB in response to employee complaints, related fatality/catastrophes, or as part of all industrial hygiene inspections in workplaces where the CDC has identified workers as having a greater incidence of TB infection then the general population. Any violations found will be classified as serious. Inspections will include a review of the employer's plans for employee TB protection and employee interviews. Employer TB control plans should include an infection control program, respiratory protection, and pre-employment and periodic skin testing. In addition, the presence of a known or suspected TB case within the previous six months will also be determined.

Hepatitis

"Hepatitis" means "inflammation of the liver." It may be caused by viruses, chemicals, drugs, autoimmune diseases, and a number of other conditions. The infections that cause hepatitis are many; most are caused by viruses, and it is this viral hepatitis that is the object of recent concern. The symptoms of hepatitis include jaundice (a yellow-green coloring of the skin or eyes), pain in the "stomach" or abdomen, fatigue and diarrhea.

Among the viruses that cause hepatitis are hepatitis A; and hepatitis B, previously called "serum hepatitis," which is a major bloodborne disease. Other less common bloodborne hepatitis viruses, include the so-called "delta" virus, hepatitis C (previously non-A, non-B hepatitis), hepatitis D, and hepatitis E.

Hepatitis A

Hepatitis A is known as Infectious Hepatitis. This disease is often associated with fecal contamination of water and is spread person-to-person through poor sanitary habits and the intake of uncooked food or unclean water. It takes about 15-50 days to develop symptoms of Hepatitis A after exposure, and symptoms usually disappear even without treatment about two weeks later. This illness is most commonly seen among children and young adults, and outbreaks are not uncommon at camps or military posts. Although this is the most common type of viral hepatitis, it should not be a problem for most fire fighters, unless an infected person prepares their meals or contaminated materials at an emergency infect them. Formalin inactivated vaccines made from attenuated HAV strains have been shown to be immunogenic, safe, and highly effective in preventing hepatitis A. Previous recommendations only included vaccinations for "high risk" uniformed personnel (e.g., HazMat, USAR, and SCUBA) and those uniformed personnel who are Hepatitis C positive or have exposure to contaminated water. However, since all uniformed personnel are potentially exposed to contaminated water via floods or accumulated water from fire suppression, all uniformed personnel shall be vaccinated.

Hepatitis B:

Hepatitis B is one the most important occupational bloodborne disease in health care providers today. Persons infected with the hepatitis B virus run the risk of developing severe health complications, including becoming a hepatitis B carrier, developing cirrhosis, liver cancer, liver failure, and death. Blood infected with the hepatitis B virus is much more infectious than HIV infected blood, and the proportion of the United States population infected with hepatitis B is much higher than the proportion infected with HIV.

Hepatitis B is spread in much the same manner as HIV virus, through sexual relations, sharing needles, or contact with blood and other body fluids. In the past, this disease has been passed through blood transfusions, but now all blood is rigorously screened for Hepatitis B before it is given to patients, and those with the illness are not allowed to donate blood. Several groups are noted to have a high risk of Hepatitis B, including parenteral (IV) drug abusers, heterosexuals with multiple partners, homosexual men, clients and staff in institutions for the retarded, prisoners, and patients of hemodialysis centers.

Injury Surveys have shown that Hepatitis B exposures accounted for 5.8% of all communicable disease exposures.

Hepatitis C

Hepatitis C virus (HCV) represents a small, but growing, risk to the fire service. HCV is a major cause of chronic liver disease and is considered a life-threatening disease. 75-85% of people with HCV infection become chronically infected, and chronic liver disease or cancer develops in approximately 70% of chronically infected people. Of those who develop chronic liver disease, 30-60% of all cases will be chronic active

hepatitis and 10-20% may develop cirrhosis. People with chronic hepatitis C are at increased risk for cirrhosis and primary hepatocellular carcinoma (liver cancer).

Most HCV transmission is associated with a direct percutaneous exposure of blood after needlesticks or sharps exposures. Health care workers who were exposed to the blood of a HCV patient through a sharps exposure developed HCV up to 7% of the time. Although the studies did not document viral transmission associated with exposure to mucous membranes or non-intact skin, the transmission of HCV from a blood splash to the eye's conjunctiva was described in one report. CDC has determined that health care workers, which includes fire fighters and emergency medical personnel, are at occupational risk for acquiring Hepatitis C infections. The IAFF "1998 Death and Injury Survey" has shown that Hepatitis C exposures accounted for 6.5% of all communicable disease exposures.

In July, 2000 the U.S. Centers for Disease Control published a Morbidity and Mortality Weekly Report (MMWR) article that mistakenly concluded that emergency response personnel are not at increased risk for Hepatitis C infection. The article purported to review data from five "studies." Most of the "studies" were not properly designed scientific studies with carefully controlled study populations and well designed data collection instruments. In fact most of the studies were just reviews of data from studies originally designed to evaluate hepatitis B.

The IAFF responded to the MMWR article by sending a letter to Secretary of Health and Human Services Donna Shalala documenting seven pages of scientific errors in the article. In summary, the CDC failed to take into account selection bias (who is included and excluded from the study population), the healthy worker effect (emergency responders are healthier that the general population and thus "normal" levels of a disease are actually higher than expected), drug screening (intravenous drug use is the most common risk factor for HCV yet many fire fighters are drug screened and thus have much lower levels of drug use than the general population). .

Hepatitis D

Hepatitis D is a variant of Hepatitis B. It is similar in its characteristics, but as a disease it is much less common. There is a blood test available to detect HDV, but the Hepatitis B vaccine will protect against Hepatitis D virus as well.

Hepatitis E

Fortunately, Hepatitis E has not yet spread around the US. It is found in other parts of the world, including Mexico, and has been seen in US travelers returning from some of these countries. It is most common among young and middle-age adults, and there is no vaccine available. However, it is similar to Hepatitis A and can be prevented in the same ways.

Human Immunodeficiency Virus (HIV)

Human immunodeficiency virus (HIV) is the virus responsible for the Acquired Immunodeficiency Syndrome (AIDS). Our understanding of the disease has progressed rapidly, but measures to prevent the spread of the disease have lagged behind. It is not an understatement to say that AIDS is the most serious public health threat the world has seen in the past 50 years. *There is no part of the U.S., or the world, for that matter, that can be considered "safe" from the threat of HIV and AIDS.*

HIV is a virus of the type known as *retroviruses*. These viruses infect certain cells in the body, incorporating their viral genetic material into the cell's own DNA. The body's cells then begin to produce the virus, and in the process, may themselves be killed. In the case of HIV, this virus infects only selected cells in the body, of which the most important are certain infection-fighting white blood cells known as lymphocytes, specifically those lymphocytes known as "helper cells" (which can be identified because they carry a marker called "CD4"). HIV can also infect certain cells in the nervous system.

HIV has been found in several body fluids, including blood, semen, vaginal secretions, saliva, and tears. However, there is no evidence that HIV can be spread by casual contact with someone infected with HIV, or through contact with saliva or tears. At this point, it is fairly well established that HIV is spread through direct contact with blood or blood products, semen, or vaginal secretions, and is acquired through "high-risk" activities including unprotected sexual intercourse, direct injection of contaminated blood by transfusion or the use of contaminated needles, or contact with contaminated blood or blood products.

Occupational transmission occurs primarily through accidental injection from contaminated needles, although there have been cases of contamination occurring through splashes of mucous membranes with contaminated blood. In contrast to Hepatitis B virus, which is easily transmitted, studies of health care workers have consistently shown that the risk of becoming infected with HIV after a needle stick is very small, less than 1 percent, and the risk of transmission by splashing of mucous membranes is even less.

Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a staphylococcal infection that is resistant to methicillin and other antibiotics that are typically used to treat staphylococcal infections.

According to the Centers for Disease Control and Prevention, up to 30% of the general population is colonized (bacteria present but not causing illness) with S. aureus in the nose. According to the CDC, susceptible and resistant strains of S. aureus are transmitted through close contact with a person who is either infected or colonized with S. aureus rather than through aerosolization. Transmission can also occur through indirect contact by touching objects such as sheets or wound dressings contaminated by the skin of an individual with S. aureus. Primary risk factors for MRSA infection include recent hospitalization or surgery, nursing home residence, open wounds (such as bed sores), and exposure to invasive medical devices. MRSA acquired in the healthcare setting is referred to as nosocomial MRSA. However, MRSA can cause

illness outside of healthcare facilities. This is referred to as community-acquired MRSA. According to the CDC, risk factors for community acquired infections include recent antibiotic use, sharing contaminated items, having active skin diseases, and living in crowded settings. Fire fighters and emergency medical technicians/paramedics may be exposed to either community acquired MRSA or nosocomial MRSA when they interact with the public. Because many calls are generated from lower acuity medical facilities (such as nursing homes) and because many individuals in the community might recently have been discharged from a hospital, the possibility of a fire fighter/EMT being exposed to a patient with nosocomial MRSA exists.

Like healthcare providers, fire fighters and EMT's are more likely to come into close contact with someone infected or colonized with S. aureus than the average person. In 1974 only 2% of all staff infections were MRSA but today it accounts for more than 64%. While MRSA originated in hospitals, community infections emerged in the early 1990's and have continued to become more prevalent. These infections began affecting healthy persons with no hospital or long-term care facility contacts. Today MRSA is a national health crisis. In 2005, there were 368,000 hospital stays with MRSA which represents 16% of people diagnosed with MRSA. In the US there are nearly 19,000 MRSA deaths per year. MRSA can be passed directly from person to person and is known to survive for days to weeks in items such as patient medical charts, couches, fabric, rarely-cleaned high-touch sites, furniture, apparatus, equipment and dust. Exposure risk is greater amongst persons with a Communal Lifestyle (Multiple personnel, confined living quarters and shared items). In a study done at the Tucson Fire Department in 2008, 7% of all surface areas tested contained MRSA. From 2003-2006, the Los Angeles Fire Department had 136 medicals claims for MRSA, 5 of which required hospitalization. In July 2007 a Texas fire fighter died of a MRSA infection and in March of 2008, a Texas Paramedic also died of a MRSA infection.

In fact, and contrary to the opposition's statements of those that oppose this legislation, fire fighters are exposed to blood on a frequent basis during their daily work activities. This bill provides for a for a reputable presumption--that is the employer can demonstrate that the exposure did not occur in the line of duty--to compensate a fire fighter if an exposure leads to a disease. Just as a fire fighter would be compensated for injuries that occurred after falling through the roof of a burning structure, a fire fighter that has an infectious disease from a job exposure would be compensated.

As our testimony has indicated, we strongly believe that sufficient evidence is available that shows fire fighters suffer from infectious diseases due to their exposures in performing the tasks involved in fire fighting and emergency medical care. We believe it is time for you to enact legislation to clearly indicate that infectious diseases are occupationally related to fire fighting.

State Presumptive Disability Laws

The following states/provinces have presumptive disability laws which recognize that fire fighters are at increased risk for certain illnesses. The laws create a presumption that the specified diseases are job related. Because the laws vary greatly from state to state, readers should use the links to review the specific state laws to determine the law's application.

Code Part: WC = Workman's Comp, RS = Retirement / Pension System,
GP = General Provisions / other section

State	Heart Disease	Lung Disease	Cancer	Infectious Diseases	Code Part
Alabama	✓	✓	✓	✓	GP
Alaska	✓	✓	✓		WC
Arizona			✓	✓	WC
Arkansas					
California	✓		✓	✓	WC & RS
Colorado			✓	✓	WC
Connecticut	✓				GP
District of Columbia					
Delaware					
Florida	✓			✓	GP
Georgia	✓	✓			RS
Hawaii	✓	✓			RS
Idaho	✓	✓		✓	WC
Illinois	✓	✓	✓	✓	RS
Indiana	✓	✓	✓		GP
Iowa	✓	✓	✓	✓	RS
Kansas	✓	✓	✓		RS
Kentucky					
Louisiana	✓	✓	✓	✓	GP
Maine	✓	✓	✓	✓	WC
Maryland	✓	✓	✓		WC
Massachusetts	✓	✓	✓		RS
Michigan	✓	✓			WC
Minnesota	✓		✓	✓	WC
Mississippi					
Missouri	✓	✓	✓		RS
Montana					
Nebraska			✓		GP
Nevada	✓	✓	✓	✓	GP
New Hampshire	✓	✓	✓		WC
New Jersey					
New Mexico	✓		✓	✓	WC
New York			✓	✓	RS
North Carolina					
North Dakota	✓	✓	✓	✓	GP
Ohio	✓	✓			WC

State	Heart Disease	Lung Disease	Cancer	Infectious Disease	Code Part
Oklahoma	✓	✓	✓	✓	RS
Oregon	✓	✓	✓		WC
Pennsylvania				✓	WC
Rhode Island		✓	✓	✓	GP
South Carolina	✓	✓			WC
South Dakota	✓	✓	✓		RS
Tennessee	✓	✓	✓		GP
Texas	✓	✓	✓	✓	GP
Utah	✓	✓		✓	WC
Vermont	✓		✓		WC
Virginia	✓	✓	✓	✓	WC
Washington	✓	✓	✓	✓	WC
West Virginia	✓	✓			WC
Wisconsin	✓	✓	✓		GP
Wyoming					
Totals	**36**	**31**	**31**	**22**	**WC = 20 RS = 10 GP = 12**

Canadian Provinces

Province	Heart Disease	Lung Disease	Cancer	Infectious Diseases	*Code Part
Alberta	✓		✓		WC
British Columbia		✓	✓	✓	WC
Manitoba	✓		✓		WC
New Brunswick	✓		✓		WC
Newfoundland					
Northwest Territory					
Nova Scotia			✓		WC
Ontario	✓		✓		GP
Prince Edward Island					
Quebec					
Saskatchewan	✓		✓		WC
Yukon					
Totals	**5**	**1**	**7**	**1**	**WC = 6 GP = 1**

DEFINITIONS

AIRBORNE INFECTIOUS AGENTS: Microbial aerosols produced by coughing, sneezing or talking that can enter a suitable portal of entry, usually the respiratory tract, and cause disease. Airborne infectious agents include, but are not limited to, mycobacterium tuberculosis and meningococcal meningitis.

BLOODBORNE PATHOGENS: Pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

CONTAMINATED: The presence or the reasonably anticipated presence of blood, body fluid or other potentially infectious materials on an item or surface.

FIRE/EMS REPORTABLE EXPOSURE: A direct introduction of a potentially infectious agent from a patient into the FIRE/EMS worker's body. These exposures include:

- PERCUTANEOUS (through the skin) A percutaneous event occurs when blood or body fluid is introduced through the skin. Examples: needle stick with bloody needle; sustaining a cut by a sharp object contaminated with blood; entrance of blood or body fluids through an open wound, abrasion, broken cuticle, or chapped skin.

- MUCOCUTANEOUS (in eye, mouth, or nose) A mucocutaneous event occurs when blood or body fluids come in contact with a mucous membrane. Example: blood or body fluid is splashed or sprayed into the eye, nose, or mouth.

- AIRBORNE An airborne exposure means contact with an individual with suspected or confirmed airborne disease or air that may contain aerosolized airborne disease.

EXPOSURE: Contact with infectious agents, such as body fluids, through inhalation, percutaneous inoculation, or contact with an open wound, non-intact skin, or mucous membrane or other potentially infectious materials that may result from the performance of an employee's duties.

HOSPITAL REPORTABLE EXPOSURE (unsuspected exposure): A hospital reportable or unsuspected exposure occurs if FIRE/EMS employees treat or transport a patient who is later diagnosed as having a serious communicable disease that could have been transmitted by a respiratory route. Hospital reportable diseases include tuberculosis and meningococcal meningitis.

NOT A REPORTABLE <u>BLOODBORNE</u> EXPOSURE:

- Blood on intact skin;
- Blood on clothing or equipment;
- Being present in the same room as an infected person;

- Touching an infected person; and
- Talking to an infected person.

POTENTIALLY INFECTIOUS MATERIALS: The following human body fluids: semen, vaginal secretions, cerebrospinal fluids, synovial, pleural fluids, pericardial fluids, peritoneal fluids, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

REGULATED WASTE: Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing materials during handling; contaminated sharps; and pathological and microbiological waste containing blood or other potentially infectious materials.

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DATE: January 25, 2010

TO: Roy De La Rosa, Intergovernmental Relations

FROM: Mark A. Grady, Principal Assistant Corporation Counsel

SUBJECT: AB 644 & SB 429

Your office has requested comments regarding the potential impact of AB 644 on Milwaukee County. As the attorney in the Office of Corporation Counsel with the primary day-to-day responsibility for advising the Employees Retirement System of Milwaukee County on pension matters and with the primary day-to-day responsibility for advising Risk Management on workers' compensation matters, I have been asked to respond to your request.

This bill would create a presumption that any county firefighter, deputy sheriff or correction officer who becomes disabled or dies due to an infectious disease (including, but not limited to, HIV, AIDS, Hepatitis A, B, C or D, and tuberculosis) that the disease was caused by employment. The only apparent defense would be a pre-employment physical examination that demonstrated that the individual had the disease prior to employment. Otherwise, the bill creates a presumption that the individual would be entitled to a disability pension or death benefit from the county retirement system due to the disease (assuming the individual could no longer work due to the disease). Under the current county retirement system, any of these employees can obtain a disability or death benefit if they become disabled by such a disease, but only if they can prove that the disease was caused by a work exposure. Thus, this bill does not create a new benefit or increase the amount of any retirement benefits that such an individual could obtain, but makes it substantially more likely that such an individual could obtain them.

First, it should be noted that this bill contravenes longstanding policy of the State of Wisconsin that leaves the adoption and administration of the county retirement to the county and disavows any State interest in the county retirement system. In section 2 of Chapter 405 of the Laws of 1965, the state legislature provided that the operation of the county retirement system is declared to be a "local affair" and

"not a matter of state-wide concern." That law essentially gave the county home rule authority over the county pension system, subject to the requirement to have a review process by a pension study commission. Because AB 644 creates presumptions for benefits in the county retirement system, AB 644 is contrary to this past history, legislation and policy. For 45 years the State has avoided any legislative involvement in any issue related to determining county employee pension benefits (as opposed to the funding of benefits through pension obligation bonds). As set forth below, there does not appear to be any compelling reason for the State to invade the previously-granted county home rule authority over the county retirement system in order to address diseases suffered by this limited group of county employees. It should also be noted that the City of Milwaukee retirement system was granted this same home rule authority in 1965 and this bill would affect the City ERS in the same manner with respect to its police officers, firefighters and EMTs.

Based on Milwaukee County's experience, the bill does not have any empirical support for its presumption. In the past two decades, it is the recollection of those persons involved in administering the county's self-insured workers compensation program that there has not been a single case of a county employee actually suffering any disability, not even temporarily, as a result of contracting one of these infectious diseases due to a work exposure. In fact, staff cannot recall any cases of employees actually contracting any of these diseases from work exposure. There have been exposures and prophylactic medications provided, but we do not believe that anyone has actually contracted one of these diseases. Therefore, the bill seems to be addressing a non-issue, from the county's experience.

Consistent with this experience, we do not know of any logical reason to assume that one of these employees is more likely to contract one of the listed infectious diseases from a work exposure than from a personal, non-work exposure. Given the protections provided at work and the fact that many of these diseases are commonly contracted from personal exposures, the factual basis for the bill's presumption is inconsistent with our knowledge and experience.

Furthermore, the bill creates inequities between classes of employees without an obvious rationale for doing so. First, other employees, such as health care workers, have the same potential work exposures as the employees referenced in the bill, but these other employees are not granted the presumption. Second, and

more fundamentally, other employees suffer other kinds of disability as a result of work exposures, but do not receive a similar presumption. Perhaps the most common such example is an employee who engages in long-term physically intensive work that can create spinal disabilities. In order to receive a disability pension, these employees must demonstrate that their disability was a result ofa work exposure. It is not readily apparent why the medical conditions and employees addressed by the bill are given greater protection than other medical conditions suffered by other employees. The current burden of proof to demonstrate that their disability is work-related does not appear to be any more onerous or difficult to meet for the conditions and employees addressed by the bill than it is on any other employee. On the other hand, to address this inconsistency by granting a similar presumption to all employees who suffer disabilities from work exposures would be a dramatic change to the current legal framework for disability retirement

Last, the bill might have the practical effect of requiring the county to begin conducting pre-employment testing for these diseases. This poses financial costs and also increases the chance that this testing will lead to other employment related claims and litigation.

I hope these comments are helpful. If you have further questions, please let me know.